

Resident's Agent Financial Agreement With [Name of Facility]

This Contract Has Been Approved by
The Maryland Department of Health and Mental Hygiene

*Denotes optional sections or paragraphs. The Facility should select the appropriate paragraph(s) before having the contract printed.

1. This Contract is between _____ (the "Facility", or "we", or "us") and _____ (the "Agent" or "you") because you have access to (use, management, or control of) the income, funds and/or assets of _____ (the "Resident") and because you are willing to act on behalf of the Resident. A checklist of the obligations and rights you have as the Resident's Agent is at Exhibit 1. The questions on the checklist must be answered by you and the checklist is incorporated into this Agreement.

2. In consideration of your payment and promises made in this Agreement, the Facility agrees to do the following:

Health Care Services

A. We will provide the Resident with general nursing care and nursing treatments such as administration of medication, preventive skin care, assistance with bathing, toileting, feeding, dressing and mobility. (Throughout this Agreement is information about which services are covered in the Facility's daily rate and which are available for an additional charge.)

B. When the Resident's doctor orders health care services which we do not have the capability to provide (with the Resident's or your approval), we will arrange for the services to be provided by an outside provider, or we will arrange for the Resident's transfer to the hospital or other health care providers.

Personal Services

C. We will provide the Resident with room and board, housekeeping services, recreational and social programs, and personal care.

D. We will provide the Resident with a reasonable amount of storage space for the Resident's personal belongings.

E. At the Resident's or your request, we will maintain the Resident's personal funds and will comply with the laws and regulations relating to our management of the Resident's funds. See Exhibit 5.

3. Paying for The Resident's Care.

A. Who Can be Required to Pay for the Resident's Care.

Only the Resident and the Resident's insurers can be required to pay for the Resident's care. You cannot be required to pay for the Resident's care from your own funds, unless you knowingly and voluntarily agree to pay for the cost of the Resident's care with your own funds.¹

¹ Whenever the phrase "you will be charged", "you pay", or "you agree to pay" are used in this Agreement, it shall be subject to the qualifications of this paragraph.

By signing this Agreement, you and the Resident agree to pay for care and services provided to the Resident with the Resident's income, funds and assets. (By signing this Agreement, you intend to bind the Resident to all obligations of this Agreement, including payment for care and services.) If you fail to pay a Facility bill, we may request a court to order such payment. You understand you may not use the assets or income of the Resident for any purpose that is not authorized by the Resident, or that is not necessary for the direct and immediate welfare of the Resident.²

You agree to provide us with all information about the Resident's finances and health. You understand that, if we later find that you knowingly provided the Facility with incomplete or inaccurate information, we will consider that a breach of this Agreement.

It is anticipated that the Resident's care will be paid for by:

- ☐ The Medicare Program;
- ☐ The Medicaid Program (also known as "Medical Assistance");
- ☐ Other third-party insurer, please specify: _____;
- ☐ You with the Resident's income, funds and/or assets;
- ☐ You with your own income, funds and/or assets;
- ☐ Other, please specify: _____.

² If there is an abuse of the Resident's funds, the person who misused the funds is guilty of a misdemeanor and, on conviction, is subject to a fine up to \$10,000. "Abuse of funds" means using the assets or income of a resident against the express wishes of the resident unless the expenditure was necessary for the direct and immediate welfare of the resident. Abuse also means using the assets or income of the resident for the use or benefit of another unless such use is for the direct and immediate benefit of the resident or is consistent with an express wish and past behavior of the resident.

It is understood that Medicare and Medicaid will make the determination concerning the Resident's medical and financial eligibility for payment by those programs.

You agree to pay either directly or through a third party payor for all items and services provided to the Resident by the Facility. You request that the Facility send the bills to :

_____.

B. Private Pay Residents.

The items and services included in our daily rate of _____ which include basic room, board and general nursing care as required by the Resident's medical condition are listed in Exhibit 2. Payment for items and services that are included in the daily rate is payable one month in advance and due on the first of each month. You agree to make timely payments.

You understand and agree that the Resident will be charged separately for additional items and services which the Resident or you (or the Resident's physician, with the Resident's or your approval) request and which are not included in our daily rates such as special nursing care, special equipment, pharmacy charges, laboratory charges and additional services such as telephone expenses, clothing, beauty and barber services and newspapers. A list of many of the ordinary items and services for which the Resident may be charged is at Exhibit 2. If the Resident, or you, or the Resident's physician (with the Resident's or your approval) request items or services other than those listed in Exhibit 2, you will be notified of the cost. Payment for these additional items and services is due within thirty (30) days after the Resident or you (or the Resident's physician with the Resident's or your approval) have requested them, and the Resident has received and been billed for them. Within ninety (90) days of receiving an item or service, or within thirty (30) days of payment, you or the Resident have the right to ask us for an itemized statement that briefly but clearly describes each item and service, the amount charged for it, and the identity of the payor billed for the service.

You understand and agree that you are responsible for paying the Facility for items and services provided to the Resident during any period of time in which the Resident is or was a resident of the Facility and during which the Resident has not been determined eligible for Medical Assistance. If you do not pay the amount owed us after receiving Facility bills and we hire a collection agency or attorney because of your breach of this Agreement, you agree to pay their fees, expenses and court costs with your own funds.

If you do not pay what is owed the Facility, you agree to apply to Medical Assistance for a determination of the Resident's income and assets available to pay the cost of the Resident's care. Once Medical Assistance determines the income and assets available to pay for the Resident's care, you agree to use such income and assets to pay the Facility's bills.³ (Your request for this determination is not the same as applying for Medical Assistance on behalf of the Resident.)

You agree to notify the Facility promptly if the Resident has insufficient income, funds, or assets to meet the Resident's financial obligations to the Facility and you agree to apply for Medical Assistance benefits in a timely manner and to cooperate fully in the Medical Assistance eligibility determination process. If you do not apply or cooperate fully in the process, the Facility may ask the court to order you to do so.

If you are no longer able to pay for the Resident's care at the Facility and the Resident is not eligible for Medical Assistance, you and the Resident will be notified of the Facility's intention to discharge the

³ If you do not request a determination by Medical Assistance, or if payment is not made with the income and assets determined to be available for the Resident's care, the Facility may ask the court to order you to obtain the determination or to make payment. If you are willfully or grossly negligent in not paying the amount determined by Medical Assistance to be available for the Resident's care, you may have to pay a civil money penalty of at least that amount with your own money.

Resident for non-payment. You agree to continue to pay the Facility's prevailing daily charges until the date of the Resident's departure.

If there is any dispute about whether the Resident should be discharged, the notice and other requirements in Section 4.F. apply. If transfer or discharge becomes necessary because you or someone else abused the Resident's funds, the Facility will request that the Attorney General investigate which may result in prosecution.

If you believe that you may need to apply for Medical Assistance later for the Resident, you may want to find out now if the Resident is "medically eligible" for nursing home payment by Medicaid. (This is not, however, the same as applying for Medical Assistance benefits.) See Exhibit 3B. [The Exhibit is written in terms of the Resident.]

C. Medicare Residents

*We participate in the Medicare Program. Medicare may pay for some or all of the Resident's nursing home care. For information on Medicare, see Exhibit 3A. [The Exhibit is written in terms of the Resident.] If the Resident is eligible for Medicare, you have the right to have claims for the Resident's nursing home care submitted to Medicare. You understand and agree to pay the Facility for amounts not covered by Medicare, including the co-payment which Medicare requires for most covered services, currently \$_____, which Medicare changes yearly. You also understand that some items and services offered by the Facility are not covered by Medicare and if you want (on behalf of the Resident) or the Resident wants any of these items or services, you agree to pay for them. (A list of the items and services not covered by Medicare and charges for them are at Exhibit 4.) If the Resident also participates in Medicare, Part B, for physical, occupational, or speech therapy or other billable charges which are not covered by Medicare, Part A, you agree to pay any required deductible, and any applicable co-insurance.

*We do not participate in the Medicare Program for inpatient services. If during the time the Resident is at the Facility you wish to have inpatient services reimbursed by Medicare, we will assist you

in finding and transferring the Resident to a facility that participates in the Medicare Program, unless you wish the Resident to remain here and pay privately for inpatient services.

D. Medicaid Residents.

[FACILITY: If you participate in Medicaid, use all paragraphs with one star (*). If you do not participate in Medicaid, use the paragraphs with two stars(**).

*We participate in the Medicaid Program. For information on Medicaid, see Exhibit 3A. [The Exhibit is written in terms of the Resident.] The Resident is not required to give up any of the Resident's rights to Medicaid benefits to be admitted or to stay here. If the Resident's private funds are used up during the Resident's stay here and the Resident is eligible for Medicaid, we will accept Medicaid payments.

*Although it is the Resident's and your responsibility to apply for and obtain Medicaid benefits for the Resident, we will assist you, by promptly providing Medical Assistance with all required information in our possession. If the Resident is eligible for Medical Assistance, the Facility may not charge, ask for, accept or receive any gift, money, donation or consideration other than Medicaid reimbursement as a condition of the Resident's admission or continued stay here.

*If the Resident receives Medicaid, most of the Resident's nursing home charges such as room, board and general nursing care are covered, although Medicaid may require you to pay some amount from the Resident's monthly income. The local Department of Social Services will tell you whether you have to pay part of the charge for the Resident's care and, if so, how much. You understand and agree to pay to the Facility on a timely basis this contribution amount as determined and periodically adjusted by the local Department of Social Services. If you fail to pay this amount, we may request a court to order such payment.

*A list of the items and services covered by Medicaid (which are published at COMAR 10.09.10.04) is posted in the Facility at the following location:

_____. If you or the Resident would like your own copy, the Facility will provide one.

*Some of the items and services that we offer are not covered by Medicaid. If you or the Resident want any items or services which are not covered by Medicaid to be provided to the Resident, you will have to pay for them. A list of the items and services not covered by Medicaid and the charges for them are at Exhibit 4. Payment for items and services that are not covered by Medicaid is due after the Resident, or the Resident's physician with your, or the Resident's approval, have requested them and the Resident has received them and you have been billed for them. Within ninety (90) days of the Resident receiving an item or service, or within thirty (30) days of payment, you or the Resident have the right to ask us for an itemized statement that briefly but clearly describes each item or service, the amount charged for it, and the identity of the payor billed for the service.

*You understand that non-payment of items and services not covered by Medicaid may result in a discharge action for non-payment of bills. If all of the Resident's personal needs have been met, you understand that money in the Resident's personal funds account may be needed to pay for items and services not covered by Medicaid which were requested by you or the Resident (or the Resident's physician with the Resident's, or your approval) and are provided by the Facility.

**We do not participate in the Medicaid Program. If, after the Resident is admitted here, the Resident no longer has sufficient funds to remain, we will assist you in finding and transferring the Resident to a facility that participates in the Medicaid Program. If there is any dispute about the Resident's transfer or discharge, the notice and other requirements described in Section 4.F. will apply.

E. Increases in Charges and Fees.

Any time we increase a fee or charge for an item or service or add a new item or service, we will provide you and the Resident with forty-five (45) days advance written notice.

F. Interest Penalties.

We may not charge you a penalty if you pay the Resident's itemized statement on time. Payment is on time if it is made within 45 days of the date the bill is postmarked, or 30 days after the end of the billing period, whichever is later. The interest penalty we charge is ____% of the amount due, calculated on either a () daily or () monthly basis. For any bill delinquent over one month, penalties will be calculated on either a () simple or () compound basis.⁴

G. Private Duty Nurses/Geriatric Aides.

*1. We do not allow private duty nurses/geriatric aides.

*2. If you or the Resident want a private duty nurse or a private duty geriatric aide for the Resident, you are responsible for selecting a person licensed and/or certified according to Maryland laws and regulations. You are also responsible for paying him or her, and for letting us know that you have hired one. The person you hire is not an employee or agent of the Facility, but he or she must meet our standards and follow our policies and procedures. Employees of the Facility may not serve as private duty nurses or private duty geriatric aides.

⁴ The Facility may not charge interest on a Medical Assistance contribution to cost of care for covered services.

H. Limitations of Liability.

The Facility is obligated to take reasonable precautions to provide the Resident and the Resident's personal belongings with security, including providing a reasonable amount of secured space for the Resident's belongings. The Facility, however, cannot be responsible for any loss or damage to the Resident's valuables or money that is not delivered into the custody of the Facility Administrator or his/her designee, unless that loss or damage is caused by the negligent or willful action of the Facility staff. The Facility's Policies and Procedures concerning the Resident's personal funds and the Resident's personal property are at Exhibit 5.

If, in spite of the Facility's best efforts, there is loss or damage to property, or injury or death to persons, which is mutually agreed to be or determined by an appropriate third party to be caused solely by the Resident, you agree to be responsible for the damage, injury, or death to the extent of the Resident's income, funds and assets. This responsibility includes payment for damages and all costs including reasonable attorneys fees required to defend a claim resulting from such damage.

In addition, although the Resident has the right to make the Resident's own health care decisions, including the right to refuse treatment, you accept responsibility to the extent of the Resident's income, funds and assets for any consequences resulting from the Resident's refusal to accept nursing or medical treatment or service considered by the Resident's physicians to be necessary for the Resident's care.

4. Resident Rights.

As a Resident of this Facility, the Resident has many rights under federal and State law. Some of those rights are listed in this section. You and the Resident will be given a written description of all of the Resident's rights.

A. The Resident's Right to Make Decisions.

The Resident has the right to make the Resident's own medical decisions, to manage the Resident's personal affairs and to access the Resident's medical records as permitted by law. If the Resident becomes incapable of making the Resident's own decisions, it may be necessary for someone else to make decisions for the Resident. For this reason, we recommend that the Resident make advance directives for medical decisions and appoint a Power of Attorney for financial decisions, but the Resident is not required to do so. It is recommended that the Resident consult with an attorney to prepare a financial Power of Attorney. As part of the admission process, you and the Resident will be given a description of the Resident's legal rights to decide about the Resident's future medical treatment, as well as information about making advance directives. If the Resident makes an advance directive, you should provide the Facility with a copy.

B. Selection of a Doctor or Other Provider.

The Resident may select the Resident's own doctor and other health care providers. The Resident's doctor and other health care providers must follow our policies.⁵ The Resident or you on behalf of the Resident, or the Resident's insurer, including the Medicaid Program, are responsible for the doctor's payment. If the Resident does not have a doctor, the Resident or the Resident's health care representative may choose one from the list of physicians who practice here. This list is attached as Exhibit 6. If the Resident or the Resident's health care representative is unable to choose a doctor, we will assign one to the Resident from this list. In case the Resident's doctor is not available when needed, our Medical Director, or designee, will take care of the Resident until the Resident's doctor is available.

⁵ If the Resident's doctor and other health care providers do not follow Facility policies and procedures, the Facility will ask the Resident to choose other providers.

Some services the Resident may require are available through outside providers. Some available outside providers and whether the Facility has a shared ownership interest with the Provider are at Exhibit 7.

C. Personal Property and Financial Affairs.

The Resident has certain rights relating to the Resident's personal property and managing the Resident's financial affairs. These rights may be exercised by you. So that you are aware of these rights the Facility's policy and procedure concerning these rights is at Exhibit 5.

D. The Resident's Right to Make Complaints and Suggest Changes in Policies and Services.

You, the Resident, or any other person may make complaints about the Resident's care in the Facility and may also suggest changes in the policies and services of the Facility. The Resident will not be harassed or discriminated against for making a complaint or suggesting a change in a policy or service. You or the Resident may present the complaints orally or in writing to Facility staff or the Administrator, or to one of the following State agencies:

Office of Health Care Quality	Department of Aging
Bland Bryant Building	301 West Preston Street
Spring Grove Hospital Center	Room 1007
55 Wade Avenue	Baltimore, MD 21201
Catonsville, MD 21228	
(410) 402-8110	(410) 767-1074
(877) 402-8219	(800) 243-3425
(800) 735-2258 (TTY)	(410) 767-1083 (TTY)
(410) 402-8234 (Facsimile)	(410) 333-7943 (Facsimile)

If the Facility is unable to resolve the complaint, it will be sent to the Department of Aging and the Office of Health Care Quality. A hearing may be requested from that Office.

E. Holding Your Bed if You Leave the Facility

Leave of Absence

If the resident is on a leave of absence from the Facility for reasons other than a hospitalization, we will hold a bed for the resident as follows:

1. Private Pay Residents:

If the resident is a private-pay resident, or are receiving inpatient care reimbursed under the Maryland Medicare Program (and the resident is not covered under Medicaid), we will hold a bed for as long as you pay for it at the current daily rate unless you notify us otherwise.

2. Medicaid Residents:

If the resident is away from the Facility on a leave of absence which is provided for in the resident's plan of care and approved by the physician, we will hold a bed for the resident for up to the maximum number of days required under Medicaid regulations, currently ____ days each calendar year. While we are holding a bed, you are still required to pay the Facility any amount for which you are responsible as determined under the Medicaid Program.

If the resident's leave of absence exceeds the total number of days paid by the Medicaid Program, the resident has the right to be readmitted to the first available gender and care-appropriate semi-private bed. Semi-private room means a two, three, or four-bed room. You may pay privately to reserve a bed for additional days.

The maximum number of days for which the Medicaid Program will pay to hold a bed for a leave of absence may be increased or decreased based upon changes in the law or the regulations established by the Maryland Medical Assistance Program

Hospitalization

3. Private Pay Residents:

If the resident is private-pay, or are receiving inpatient care

reimbursed under the Maryland Medicare Program (and the resident is not covered under Medicaid), we will hold a bed for as long as you pay for it at the current daily rate unless you notify us otherwise.

4. Medicaid Residents:

If Medicaid pays for part or all of the resident's nursing home care or has filed an application for Medicaid and the resident's needs to be hospitalized, you may pay privately to reserve a bed for the days you are in the hospital. If your hospital stay exceeds the number of days you have paid the nursing home to reserve a bed, you have a right to be readmitted to the first available gender and care-appropriate semi-private bed. A hospital stay is not a leave of absence.

Third-party Payors

5. Other third-party payors may or may not have a bed hold policy. We will discuss this if it applies to you.

F. **Transfer and Discharge.**

The Resident has the right to remain here, and may not be transferred or discharged against the Resident's will, except for the following reasons: (a) the Resident's condition has improved so that the Resident no longer needs the services we provide; (b) the transfer or discharge is necessary for the Resident's welfare and the Resident's needs cannot be met by the Facility; (c) the health or safety an individual in the Facility is endangered; (d) you, after reasonable and appropriate notice, have failed to pay, or through the Resident's insurers have failed to pay, for a stay at the Facility; or (e) the Facility ceases to operate.

If we decide that the Resident should be transferred or discharged for one of these reasons, we will notify the Resident and you, the Resident's family member, guardian or representative, by letter 30 days in advance. We will also notify the Office of Health Care Quality and the Department of Aging. If the Resident is transferred because of an emergency situation, we will provide the required notice as soon as reasonable. The involuntary discharge letter will contain the reasons for the transfer or discharge and its effective date, and the Resident's rights

regarding discharge or transfer. The letter will also tell the Resident and you how to appeal our decision to transfer or discharge the Resident, by requesting a hearing, and will tell you what agencies may assist you.

If the Resident is to be discharged involuntarily, we will comply with current law in making discharge or transfer arrangements.

You and the Resident must cooperate and assist in the discharge planning, including cooperating with and assisting other facilities considering admitting the Resident and cooperating with governmental agencies. If you or the Facility believe that an abuse of funds contributed to the transfer or discharge for non-payment, you may, or the Facility will ask the Attorney General to investigate and make referrals to other governmental agencies.

5. Right to End This Contract.

If you or the Resident decide to end this Contract and the Resident leaves the Facility, the bill becomes due and payable on the day the Resident leaves. You or the Resident must give us _____ days notice to terminate this contract. If the Resident leaves before the end of that time, you must still pay for each day of the required notice unless we fill the bed before the end of the notice period.

In the event the Resident dies while a resident of the Facility, please designate who we should contact:

Relative _____ or Friend:
_____.

Funeral _____ Home:
_____.

Unless you have instructed us otherwise, we will immediately contact the individual(s) listed above to make funeral arrangements. If we are unable to reach the individual(s), we will contact the funeral home directly.

6. Additional Documents.

It is not possible to cover everything that is important to the Resident's stay in our Facility in the body of this Contract. Therefore, we have included additional important documents as Exhibits. These Exhibits are part of this Contract. Please verify that you received all of the Exhibits and that the contents of the Exhibits were explained to you. Place your initials on the line next to the description of each Exhibit.

_____ Exhibit 1. Obligations and Rights of an Agent.

_____ Exhibit 2. Private Pay:

- A. Items and Services Included in the Daily Rate;
- B. Items and Services Not Covered by the Daily Rate.

_____ Exhibit 3.

- A. How to Apply For and Use Medicare and Medicaid Benefits.
- B. Medical Assistance Nursing Facility Services (Medicaid Medical Eligibility Form)

_____ Exhibit 4. Items and Services Not Covered by Medicaid.

_____ Exhibit 5. Policies and Procedures Concerning The Resident's Personal Funds and The Resident's Personal Property.

_____ Exhibit 6. Physicians Who Practice at the Facility.

_____ Exhibit 7. Services Provided by Outside Health Care Providers.

7. Changes In Law.

Any provision of this Contract that is found to be invalid or unenforceable as a result of a change in State or Federal law will not invalidate the remaining provisions of this Contract and, it is agreed that to the extent possible, you and the Resident and the Facility will continue to fulfill their respective obligations under this Contract consistent with the law.

IN WITNESS WHEREOF, the parties have executed this Contract on this _____ day of _____, 20____.

WITNESS:

[NAME OF FACILITY]

By: _____
Name: _____
Title: _____

WITNESS:

AGENT:

Title

(Indicate whether you are: (1) a court-appointed guardian of the property (or of the person with court granted authority to handle the Resident's funds); (2) a power of attorney appointed by the Resident;⁶ (3) a family member; or (4) other individual with access to (use, management, or control of) the income, funds and/or assets of the Resident.

⁶ By signing as Power of Attorney, I acknowledge I am signing as an Agent as defined in this document and by Title 19, Health General Article, Annotated Code of Maryland.

EXHIBIT 1

OBLIGATIONS OF THE AGENT

Only an Agent may sign this Agreement. An Agent is an individual who manages, uses or controls a Resident's income, funds and assets that legally may be used to pay for the care or services that a Resident receives from a nursing facility. An Agent is obligated to use the Resident's income, funds and assets to pay the Facility for the Resident's care. The financial obligation of the Agent is limited to the amount of the Resident's income, funds and assets. The Agent assumes no personal liability for the Resident's stay at the Facility unless the Agent voluntarily agrees to be personally responsible for any payments required under this Contract which are not paid by the Resident or a third-party insurer. (See question E.1., below.)

A nursing facility may not require an Agent to sign the Admissions Contract unless the applicant has been adjudicated disabled by a court or the applicant's physician has certified, in writing, that the applicant is incapable of understanding or exercising his or her rights and responsibilities. However, an Agent may voluntarily agree to sign the Admissions Contract, on behalf of an incapable applicant or at the request of a capable applicant even when the above conditions are not met.

A. ONE OF THE FOLLOWING CONDITIONS MUST BE MET IN ORDER TO REQUIRE YOU AS THE AGENT TO SIGN THIS ADMISSIONS CONTRACT. (These are not required if you are signing voluntarily.)

1. Has the applicant been adjudicated disabled by a Court?
Yes ___ or No
2. Has the applicant's physician certified, in writing, that the applicant is incapable of understanding or exercising his or her rights or responsibilities?
Yes ___ or No

(NOTE: Documentation verifying the above must be included in the Resident's record if a third-party's signature is required by the Facility.)

B. PLEASE INITIAL THOSE QUESTIONS WHICH DESCRIBE YOUR AUTHORITY FOR ACTING AS THE RESIDENT'S AGENT.

Are you signing this Contract:

___ 1. At the request of the Resident?

_____ Signature verification of Resident

___ 2. As a family member or other person with authority to manage, use or control the Residents income, funds and/or assets?

___ 3. As a Guardian of the Property appointed by a Court?

___ 4. As a financial Power of Attorney appointed by the Resident?

(NOTE: The Agent shall provide documentation of his or her authority, where applicable.)

C. AS THE RESIDENT'S AGENT, YOU HAVE CERTAIN OBLIGATIONS WHICH ARE LISTED BELOW. FAILURE TO MEET THESE OBLIGATIONS CAN RESULT IN CIVIL AND CRIMINAL PENALTIES AS DESCRIBED IN THIS EXHIBIT. INDICATE THAT YOU AGREE TO ASSUME EACH OBLIGATION BY INITIALING EACH IN THE SPACE PROVIDED.

___ 1. I agree to pay the Facility bill in a timely manner to the extent that the Resident has income, funds and/or assets to pay for such services.

___ 2. In the event the Resident is a beneficiary of Medicare, Medicaid, or any other third-party payment plan, I agree to pay all co-payments, co-insurance and deductibles, and all charges for non-covered items and services, together with any applicable late fees, to the extent of the Resident's income, funds and/or assets.

___ 3. In the event I have not paid a current bill to the Facility for the Resident's care, I agree to apply to Medical Assistance for a determination of the funds available to pay for the cost of the Resident's care.

(NOTE: I understand if I fail to seek this determination, the Facility will seek a Court Order requiring me to do so.)

___ 4. In the event the Resident's private income, funds and assets are exhausted during the Resident's stay, I agree to apply for Medical Assistance benefits for the Resident in a timely manner, and to cooperate fully in the eligibility process.

___ 5. I agree to apply for Medicare, Veterans Administration or other third-party benefits which may be available to cover the cost of the Resident's care at the Facility.

___ 6. In the event the Resident is applying for admission on a private pay basis, I agree to assist the Resident in providing financial information required by the Facility to determine the extent of the Resident's income, funds and/or assets.

(NOTE: If it is ever determined that I knowingly or willfully participated in the disclosure of incomplete or inaccurate information, the incomplete or inaccurate disclosure is considered a breach of this Contract and the Facility reserves the right to pursue all available legal remedies against me including, but not limited to, an action for breach of contract.)

D. PENALTIES

I understand that I could be subject to both civil and criminal penalties for failure to meet my obligations as an Agent as follows:

1. If I willfully or with gross negligence fail to pay the required amounts from the Resident's income, funds or assets, as determined available by Medical Assistance, I understand that I could be subject to a civil money penalty for an amount at least equal to the amount due the Facility. This amount would be paid from my own funds.
2. If I willfully or with gross negligence fail to seek on behalf of the Resident all assistance from Medical Assistance which may be available to the Resident, or fail to cooperate fully in the eligibility determination process, I understand that I could be subject to a civil money penalty of up to \$10,000. This amount would be paid from my own funds.
3. If I willfully or with gross negligence fail to cooperate and assist in the discharge planning process for the Resident, I understand that I could be subject to a civil money penalty of up to \$10,000. This amount would be paid from my own funds.
4. If I "abuse" the Resident's funds, I understand that I could be found guilty of a misdemeanor and, on conviction, be subject to a fine of up to \$10,000. This amount would be paid from my own funds. "Abuse of funds" means using the assets or income of a Resident against the express wishes of the Resident unless the expenditure was necessary for the direct and immediate welfare of the Resident. Abuse also means using the assets or income of the Resident for the use or benefit of another unless such use is for the direct and immediate benefit of the Resident or is consistent with an express wish and past behavior of the Resident.

E. IN ORDER TO PROPERLY PLAN FOR THE RESIDENT'S NEEDS, IT IS IMPORTANT THAT WE HAVE THE ANSWERS TO THE FOLLOWING QUESTIONS. PLEASE INDICATE "YES" OR "NO" TO EACH AND INITIAL. YOU ARE NOT REQUIRED TO ANSWER "YES" AND AGREE TO ASSUME RESPONSIBILITY FOR THE ISSUES ADDRESSED IN E.1. - E.7 (THESE OBLIGATIONS ARE NOT REQUIRED FOR THE RESIDENT'S ADMISSION);

HOWEVER, YOU MAY VOLUNTARILY ANSWER "YES" AND AGREE TO ASSUME ANY OR ALL OF THE FOLLOWING:

___ 1. Do you knowingly and voluntarily agree to make payments required under this Agreement from YOUR OWN RESOURCES?

Yes ___/No ___ Initials

___ 2. Do you agree that in the event of the Resident's death, you shall take responsibility for all burial arrangements for the Resident and for removal of all of the Resident's personal property from the Facility, subject to your legal authority to accept the property:

Yes ___/No ___ Initials

___ 3. In the event you are not able to remove the Resident's personal property promptly and, consequently, the Facility is unable to admit another Resident to the deceased Resident's room, do you agree to:

a. Pay for removal and storage of the property?

Yes ___ [If yes, () with the Resident's funds/
() with your funds]

No ___ Initials

b. Pay for the room until you are able to move the Resident's personal property?

Yes ___ [If yes, () with the Resident's funds/
() with your funds]

No ___ Initials

___ 4. If the Resident or his or her Representative wants to obtain private duty nurses or geriatric aides in accordance with the requirements of this Agreement, do you agree to be responsible to make arrangements for those services?

Yes ___/No ___ Initials

___ 5. Payment for services of private duty nurses or geriatric aides shall be made out of the Resident's income, funds and

assets unless you agree to pay. Do you knowingly and voluntarily agree to pay for the services of private duty nurses from your own resources if these services are requested and the Resident does not have sufficient funds to pay for such services?

Yes ___/No ___ Initials

___ 6. In the event the Resident or his or her representative seeks to terminate this Contract, do you agree to give the notices required under Paragraph 5 of this Contract?

Yes ___/No ___ Initials

___ 7. In the event that the Resident is involuntarily discharged from this Facility, and if other arrangements cannot be made, do you agree to accept the Resident into your custody, if it is medically and legally appropriate?

Yes ___/No ___ Initials

RIGHTS OF THE AGENT

F. YOU HAVE THE RIGHT TO COPIES OF THE FOLLOWING DOCUMENTS. DO YOU ACKNOWLEDGE RECEIPT OF THE FOLLOWING DOCUMENTS:

1. A copy of this Admission Contract;
2. The Facility Handbook (where applicable);
3. A copy of Federal and State Residents' Rights;
4. A list of the Facility's charges, including the charges not included in the per diem rate;
5. A list of health care providers offering services at the facility and their current charges; and
6. Others:

Yes ___/No ___ Initials

THE DOCUMENTS IN F.1 THROUGH F.6 MAY BE AMENDED FROM TIME-TO-TIME CONSISTENT WITH STATE AND FEDERAL LAW AND REGULATIONS. WHEN AMENDMENTS ARE MADE, YOU WILL BE PROVIDED A COPY.

- G. YOU HAVE THE RIGHT TO BE NOTIFIED BY THE FACILITY OF ANY EVENT OR OCCURRENCE INVOLVING THE RESIDENT WHICH DIRECTLY AFFECTS YOUR OBLIGATION UNDER THIS AGREEMENT.

I, _____, have read the information in this Exhibit 1. I have had the opportunity to ask questions and I fully understand and accept all of the obligations I have in acting as the Resident's Agent.

Witness

Agent

EXHIBIT 2

FOR PRIVATE PAY RESIDENTS

A. Items and Services Included in the Daily Rate.

The items and services included in the daily rate, and their related charges, are listed below:

Description of Items & Services Included In The Daily Rate*	
1.	Room
2.	Board
3.	Social Services
4.	Nursing care, including: <ul style="list-style-type: none">a. The administration of prescribed medications and provision of treatments and diet;b. The provision of care to prevent skin breakdown, bedsores and deformities;c. The provision of care to keep the resident comfortable, clean and well-groomed;d. The provision of care to protect the resident from accident, injury and infection;e. The provision of care necessary to encourage, assist and train the resident in self-care and group activities.
5.	Other:

* Revise this list to accurately reflect those items and services included in the Facility's Daily Rate.

B. Items and Services Not Included in the Daily Rate.

The items and services available in the facility that are not included in the daily rate are listed below. The Resident may be charged for these items and services if you or the Resident (or the Resident's physician with the Resident's or your approval) ask for them and the Resident receives them. If the Resident is eligible for Medicare and/or private insurance and you believe that Medicare and/or the private insurance may cover an item or service listed below, you should ask us to submit the bill to Medicare and/or the private insurer. The services marked (*) may have a separate supply charge. You will be notified of those charges at the time the supplies are ordered.

Description of Items & Services Not Included in the Daily Rate	Charge
Beauty and Barber *	
Catheter Care *	
Colostomy Care *	
Decubitus Care *	
Feeding: hand, tube *, special diet	
Incontinent Care *	
IV Therapy *	
Laundry*	
Laboratory (Billed by the Laboratory; call _____ for charges)	
Oxygen Therapy *	
Pharmacy (Billed by the Pharmacy; call _____ for charges)	

Description of Items & Services Not Included in the Daily Rate	Charge
Radiology (x-ray services) (Billed by the Radiologist; call _____ for charges)	
Rental Fees: walker; geriatric chair; wheelchair; pressure mattress; trapeze	
Suctioning [*]	
Tracheotomy Care [*]	
Other:	

EXHIBIT 3A

HOW TO APPLY FOR AND USE MEDICARE AND MEDICAID BENEFITS

The chart below summarizes the Medicare and Medicaid programs. It also tells you who to call for more detailed information. If you have questions, our staff will also help you.

	MEDICARE	MEDICAID
WHAT'S COVERED	<ol style="list-style-type: none"> 1. Care in a hospital; 2. If you are admitted to an approved facility within thirty (30) days following a three-day qualifying hospital stay (not including the day of discharge) Medicare may cover up to 100 days of skilled nursing and rehabilitation care. This coverage depends on your medical condition, and whether your doctor orders the care on a daily basis (not including weekends). If these conditions are met, Medicare provides full coverage for the first 20 days. You must make a copayment after that. The following services are examples of skilled care: <ol style="list-style-type: none"> a. Injections & feedings given through an IV; b. Tube feedings; c. Application of a dressing that involves prescription medication; d. Treatment of pressure ulcers; 3. Dietary services; 4. Activities program; 5. Room/Bed maintenance services; 6. Routine personal hygiene items; 7. Medically-related social services; 8. Rehabilitation based on physician orders. 9. Medically necessary doctor's services. 	<p>Medicaid is a comprehensive program that will cover most of the costs of a nursing home stay.</p>

	MEDICARE	MEDICAID
YOUR CONTRIBUTION	Medicare does not pay 100% of the cost of covered services. You will be required to pay part of the charges. Your payment may be called a "copayment," "deductible" or "premium," depending on the type of care provided. If you receive Medicaid, Medicaid may pay for any payment that you are responsible for under Medicare.	Depending on your income, you may be required to make a contribution toward the cost of your care. The amount of any contribution will be calculated by the local Department of Social Services. You will need to pay this contribution to the Facility for every month in which you are eligible for Medicaid, including partial months.
WHO'S ELIGIBLE	People 65 years old or older who are eligible to collect old-age benefits under Social Security are eligible. Persons who receive Social Security disability benefits for at least 24 months, or have been found eligible for Medicare by the Social Security Administration because they have end stage renal disease requiring regular dialysis or kidney transplant are also eligible.	Eligibility is based on your income and resources (assets): 1. <u>Resources</u> : The local Department of Social Services will evaluate your resources (assets) and tell you whether you qualify. Generally, you cannot have more than \$2,500 in resources. The following are examples of things <u>not</u> counted as

	MEDICARE	MEDICAID
		<p>resources:</p> <ul style="list-style-type: none"> a. Your house if your spouse or dependent relative lives there or if you express an intent to return there; b. Household goods; c. Personal property in your possession in the nursing home; d. A certain amount of money for burial arrangements. <p>The value of other assets transferred within 36 months of your application for Medicaid may be considered as available to pay for your care at the</p>

	MEDICARE	MEDICAID
		<p>Facility.</p> <p>1. <u>Income</u>: You should contact the local Dept. of Social Services to find out whether your income makes you eligible. That phone number is listed on the next page. If you qualify, \$40 per month of your income is protected for your personal use while in the Facility.</p> <p>2. <u>Assets</u>: The local Dept. of Social Services will also be able to evaluate your assets and tell you whether you qualify . The following are examples of things <u>not</u> counted as assets: arrangements.</p>
		NOTE: You will not

	MEDICARE	MEDICAID
		<p>be eligible for some period of time if you have transferred resources for less than fair market value to someone other than your spouse, or a blind or disabled child, within thirty-six months before you apply for Medicaid.</p> <p>2. <u>Income</u>: If your income is less than the facility's private pay rate, you may be eligible. If you qualify, \$40.00 per month of your income is protected for your personal use while in the facility. Medicaid may protect other portions of your income as well.</p>
HOW TO APPLY	Contact the local Social Security Office at the following address and phone number:	Contact the local Department of Social Services at the following address and phone number:

	MEDICARE	MEDICAID
WHO TO CONTACT IF YOU HAVE A QUESTION OR A PROBLEM	To learn more about Medicare coverage of nursing home expenses, and about how to appeal a Medicare denial of payment, contact Beneficiary Relations of the Centers for Medicare and Medicaid Services (CMS) at 1-800-633-4227 or call the Senior Information and Assistance Program in your county.	If your application for Medicaid is denied, your coverage is terminated, or a service is not covered, you may appeal that decision according to the instructions contained in the notice provided to you.
RETROACTIVE COVERAGE	Not applicable.	The nursing home services that you received in the 3 months prior to your application for Medicaid may be covered by Medicaid, if you specifically request this coverage.

EXHIBIT 3B
MEDICAL ASSISTANCE
NURSING FACILITY SERVICES

Important Information - Please Read Carefully

The Medical Assistance Program, also known as Medicaid, is a governmental program to help people pay their medical bills. To be eligible, one must be financially unable to pay the cost of medically necessary care. Eligibility, therefore, has two tests: (1) financial eligibility; and (2) medical eligibility. Financial eligibility is determined by the local Department of Social Services. Medical eligibility is determined by the Medical Assistance Program.

It is important to understand that even if you can no longer afford to pay for nursing facility care, Medical Assistance will not pay for nursing facility services unless you are also medically eligible for these services. You may obtain information regarding financial eligibility from the local Department of Social Services at no cost. If you want to know if you are medically eligible before you apply for Medicaid Assistance, for a nominal fee, you may obtain an assessment of your medical eligibility from the same contractor who currently functions as the State Review Agent for the Medical Assistance Program.

To obtain an assessment of your potential medical eligibility, you may call the current State Review Agent, Delmarva, at 1-410-770-8326 or you may write to Delmarva at:

Delmarva
Attn: Shelia Marshall
Delmarva Foundation
9240 Centerville Road
Easton, Maryland 21601

Medical conditions of nursing facility residents change over time. Therefore, the assessment you receive is advisory only and is not binding on the Medical Assistance Program. The assessment will, however, assist you in making an informed decision regarding your need for nursing facility care or for less intensive community based care. Community alternatives to nursing facility services are available. Information

about community alternatives can be obtained from your Local Health Department, Geriatric Evaluations Services and from your local Area Agency on Aging Office.

If you want additional information regarding Medical Assistance nursing facility benefits, please do not hesitate to call (410)767-1712 and ask for the Nursing Facility Program Specialist.

EXHIBIT 4
FOR MEDICARE AND MEDICAID RESIDENTS

Items and Services Not Covered By Medicare or Medicaid

Items and services not covered by Medicare or Medicaid and related charges are listed below. You may be charged for these items and services if the Resident or you (or the Resident's physician with the Resident's or your approval) ask for and receive them. The services marked with an (*) may have a separate supply charge. You will be notified of those charges at the time the supplies are ordered.

<u>Item or Service</u>	<u>Charge</u>
Audiology Services;	
Beauty Salon and Barber Shop [*] ;	
Cosmetic and Grooming Items;	
Dental Services (Billed by Dentist)	
Flowers and Plants;	
Newspapers (and other reading materials);	
Occupational and Physical Therapy Services [*] ;	
(unless they are part of a specialized rehabilitative therapy services program meeting certain regulatory requirements);	
Personal Clothing;	
Personal Comfort Items (including smoking materials);	
Private Rooms ^{**} ;	
Privately Hired Nurses and Aides;	
Services of Other Health Care Providers	
[Attach Facility Specific List];	

^{**} If you receive Medicaid and the Facility places you in a private room, the Facility may not charge you or anyone else an additional cost for a private room.

Item or Service

Charge

Social Events and Entertainment Outside the Scope of the Facility's Activities Program;
Specially-Prepared or Alternative Food Requested Instead of Food Generally Prepared by the Facility;
Speech Therapy Services*;
Telephone;
Television;
Transportation by ambulance to a physician's office.

EXHIBIT 5
POLICIES AND PROCEDURES CONCERNING THE RESIDENT'S
PERSONAL FUNDS AND THE RESIDENT'S
PERSONAL PROPERTY

A. The Resident's Rights

1. The Resident has the right to keep and use the Resident's personal property, including some furnishings and clothing, so long as there is enough space and other residents are not inconvenienced. The Resident also has the right to security for the Resident's personal possessions.

2. We cannot require the Resident to deposit the Resident's personal funds with us. The Resident may, however, choose any person to manage the Resident's funds, including the Facility.

3. If the Resident decides to have us manage the Resident's personal funds during the Facility's business hours, the Resident may withdraw the Resident's money that we keep in the Facility. If we have deposited any of the Resident's funds in a bank, the Resident may obtain those funds within three banking days, provided the funds have cleared.

4. If the Resident needs help to perform the Resident's banking transactions, the Resident may give an employee of our Facility who has been approved by the Administrator legal authority to access the Resident's account. This authority is called a "limited power of attorney." To give an employee this authority, the Resident will need to complete a special form. The form has been approved by the Maryland Department of Health and Mental Hygiene and is available in the facility.

5. The Resident has the right, during normal business hours, to inspect our written records that concern the Resident's personal funds.

6. The Resident or any other person acting on the Resident's behalf has a right to file a complaint if it is believed that the Resident's funds, valuables or other assets have been stolen or damaged. The agencies to contact in order to make a complaint are listed below:

- a. The Maryland Department of Aging, for persons 65 years old or older:

301 West Preston Street
Baltimore, MD 21201
(410) 767-1074 - (800)243-3425 or
(410) 767-1083 (for the hearing impaired)
(410) 333-7943 (Facsimile)

- b. The local Department of Social Services for persons of any age:

{FACILITY: Please Provide Address & Phone #}

- c. The Office of Health Care Quality, regardless of the Resident's age:

Spring Grove Center
55 Wade Avenue,
Catonsville, Maryland 21228
(410) 402-8108 - (877)402-8219
(410) 735-2258 (for the hearing impaired)
(410) 402-8234 (Facsimile)

B. Our Responsibilities

1. We will provide a reasonable amount of secure space for you to keep the Resident's clothing and other personal property. We must investigate any damage to or loss of the Resident's personal property.

2. If the Resident wants us to manage \$50.00 or less of the Resident's personal funds, we will deposit this money in a non-interest bearing account or a petty cash fund.

3. If the Resident wants us to manage more than \$50.00 of the Resident's personal funds, we will deposit this money in an interest bearing account that is insured by the federal government. This account will be separate from the accounts we use to operate the facility. In

addition, we will credit the Resident with all interest earned on the Resident's money.

4. We will maintain a full, complete and separate monthly accounting of the Resident's personal funds, which is available to you for inspection. We will also provide the Resident with a quarterly statement of the activity of the Resident's account.

5. If the Resident receives Medicaid benefits, we will notify the Resident if the Resident's account balance becomes too high. If the Resident is to remain eligible for Medicaid, the Resident's account balance must be under a certain dollar limit that is established by the federal government and may change periodically.

6. We may not use the Resident's personal funds to pay for an item or service that Medicare or Medicaid covers.

7. We will maintain adequate fire and theft coverage to protect the Resident's funds and personal property that are kept at the Facility. We shall also obtain a surety bond or otherwise assure* the security of the Resident's personal funds that are deposited with the Facility.

8. If the Resident is discharged, there are several things we must do:

- a. We will immediately return the Resident's personal funds in our possession. If we have deposited the Resident's personal funds in a bank account, we will make this money available to the Resident or the Resident's agent within three banking days; and
- b. If we are the Resident's agent payee for Social Security benefits, we will promptly ask the Social Security Administration to name a new agent payee

* CMS has determined that neither self-insurance nor FDIC insured accounts are an acceptable alternative.

and we will transfer the Resident's money to that person.

9. In the event of the Resident's death, there are several things we must do:

- a. We will convey the Resident's personal funds and a final accounting of those funds to the person in charge of administering the Resident's estate within 30 days;
- b. We will immediately notify any government agency that paid for all or part of the Resident's care in our Facility. That agency shall have the right to assist us in determining what to do with the Resident's property;
- c. If a government agency did not pay for the Resident's care, we will immediately notify the Resident's agent or next of kin to determine what to do with the Resident's property;
- d. If we have the Resident's funds, valuables or other assets in our possession, we will hold them until the appointed Personal Representative of the Resident's estate presents a copy of the certified Letters of Administration to us, or until we receive authorization from another legal representative as established by State law;
- e. We will make reasonable attempts to locate the Resident's Personal Representative and the Resident's heirs. If no claim is made on the Resident's funds, valuables or other assets in our possession within six weeks of the Resident's death, we will write the State Office of the Comptroller for direction.

10. If we are in possession of the Resident's funds, valuables or other assets for more than one year from the date of the Resident's transfer or discharge, we will transfer the Resident's funds, any interest on the Resident's funds, and the Resident's valuables or other assets

to the State Office of the Comptroller. We will also notify the Comptroller's Office of any account(s) in the Resident's name of which we have knowledge.

EXHIBIT 6

PHYSICIANS WHO PRACTICE AT THE FACILITY

Physician's Name	Physician's Address & Phone Number

EXHIBIT 7
SERVICES PROVIDED BY OUTSIDE HEALTH CARE PROVIDERS

Some of the services available in the Facility, such as pharmacy services, are provided by outside health care providers. These services, and information about the providers, appear below. The Resident's own provider or one of those listed below may be used.

Type of Service	Provider's Name, Address & Telephone Number	Whether the Facility has a Shared Ownership Interest with the Provider